DEATH AND DYING
IN
LONG TERM CARE FACILITIES

OPERATIONAL
GUIDELINES

Province of British Columbia
Ministry of Health
Continuing Care Division

AUGUST 1989

Province of British Columbia

Ministry of Health

Continuing Care Division
Parliament Buildings
Victoria
British Columbia
V8V 4V7

November 3, 1989

To: All Facility Operators

The issues around death and dying in long term care facilities are becoming more and more complex. Many operators have indicated that some guidance or assistance in this area would be helpful and greatly appreciated. In response to this need to preserve the dignity of the client during the dying process, the Continuing Care Division, in conjunction with a Steering Committee, has produced a pair of documents, which we have forwarded for your review and consideration.

1) Death and Dying in Long Term Care Facilities - REPORT; and

2) Death and Dying in Long Term Care Facilities - OPERATIONAL GUIDELINES.

I wish to emphasize that these documents are intended primarily as educational and reference material. They should not be construed as "recommended policies" but, rather, as a vehicle for stimulating thoughtful discussion on this timely topic. If your facility chooses to develop policies in this area, these documents should only be one of many considerations in this process.

We realize we took some "risks" in releasing these documents at this time, but feedback from the industry indicated that there was a pressing need for information in this area and we felt this need superceded spending more time to "fine tune" these documents. We are very interested in your feedback and comments on these documents. After such feedback, we are prepared to make changes and produce a revised version for your consideration.

If you have comments or feedback, or if you have any questions with respect these documents, please contact Mr. Andrew Butler, Regional Director, Metro/Sunshine Coast (387-2527).

Sincerely,

Paul Pallan
Executive Director
Continuing Care Division

c.c. Mr. Andrew Butler
Management Committee

DEATH AND DYING
IN
LONG TERM CARE FACILITIES

OPERATIONAL
GUIDELINES

Province of British Columbia
Ministry of Health
Continuing Care Division

AUGUST 1989

90-03084/

FOREWORD

In response to rising concerns from the long term care industry with regards to Living Wills and Do-Not-Resuscitate Orders, the Continuing Care Division has conducted a formal review of this subject. Their significance and role in the absence of natural death legislation, present medicolegal issues which require examination within the context of long term care.

A Steering Committee (Mr. Andrew Butler, Regional Director, Metro/Sunshine Coast and Residential Care; Mr. Gerrit Clements, Senior Solicitor, Legal Services; Dr. John Higgins, Medical Consultant, Hospital Programs Division) was established to facilitate the review, conducted by a consultant for the Continuing Care Division, Dr. Patricia Ngan.

As a result, two documents have been produced and are recommended by Mr. Paul Pallan, Executive Director, Continuing Care Division, for use in long term care industry as reference material and general guidelines:

(1) Death & Dying in Long Term Care Facilities — **REPORT**
(2) Death & Dying in Long Term Care Facilities — **OPERATIONAL GUIDELINES**

The **REPORT** is intended as educational literature, and the **OPERATIONAL GUIDELINES** as a guide for facilities to use in developing policies regarding Death and Dying.

In closing, the author of these documents expresses her gratitude to all Committee members, reviewers and the British Columbia Medical Association — Continuing Advisory Subcommittee (CASC) on Health Care of the Elderly and Long Term Care, for their comments and advice throughout this process.

TABLE OF CONTENTS

1 INTRODUCTION

1.1 PURPOSE

1.2 BACKGROUND

1.3 DEFINITIONS

2 GUIDELINES FOR DEVELOPING POLICIES

2.1 GENERAL

2.2 'DEGREE OF INTERVENTION' ORDER

2.3 COMPETENCE

2.3.1 COMPETENT CLIENT
2.3.2 INCOMPETENT CLIENT

2.4 SUDDEN COLLAPSE

2.5 'DEGREE OF INTERVENTION' CONFERENCE

2.6 COMMUNICATION

2.7 REVIEW

3 GUIDELINES FOR ESTABLISHING PROCEDURES

3.1 GENERAL

3.2 CLIENT ORIENTATION

3.3 COMPETENCE ASSESSMENT

3.4 'DEGREE OF INTERVENTION' CONFERENCE SCHEDULING

3.5 DOCUMENTATION/COMMUNICATION

3.6 SUDDEN COLLAPSE — PLAN OF ACTION

DEATH AND DYING IN LONG TERM CARE FACILITIES

Guidelines of Sections 2 and 3 provide a basis for each long term care facility to develop policies and procedures with regards to death and dying, in the management of their clients. The resulting policies should be made available to the public.

Cross Reference:

DEATH AND DYING IN LONG TERM CARE FACILITIES

Decisions with respect to treatment in long term care are made under a wide variety of circumstances, often without guidance or direction of a client's wishes.

There is no legislation in Canada at present to protect physicians and care staff from civil or criminal action in this regard. Due to potential liability, policies will be developed to provide guidance, and to set the standard of care for health care workers in the industry.

Each facility will develop policies regarding **Death and Dying** based on these Operational Guidelines issued by Continuing Care Division (Sections 2 and 3).

Lifesaving Measures

Lifesaving measures include, but are not limited to activities such as: life support systems, organ transplants, vascular surgery, cardiopulmonary resuscitation (CPR), blood transfusions, intravenous and naso-gastric feeding.

Living Will

The Living Will is a declaration (not an Order) made by an individual while competent, which indicates whether to withhold or administer treatment (and the type of treatment) during terminal stage of illness, if he/she becomes incompetent or is unable to express his/her wishes at that time. The onus is on the individual to make such a declaration.

The Living Will is not an Order (unlike the DNR Order which is written by a physician and legally binding on care staff), but is an important indication of a client's wishes, (made while competent) regarding treatment.

Do-Not-Resuscitate (DNR) Order

This Order is written by a physician after consultation with the patient and/or family members.

It is binding on care staff and remains effective (until retraction by a physician), unless the patient's condition has changed significantly in a manner not previously foreseeable. The Order indicates that CPR should not be attempted if the individual experiences cardiac arrest.

Proxy

A person designated by a client, or by default, to act on behalf of the client in making treatment decisions and in medically-related matters, if he/she becomes incompetent. Its validity, however can only be legally recognized under proper legislation which presently does not exist in British Columbia.

'Degree of Intervention' (DI) Order

The proposed 'DI' Order in the long term care setting would be analogous to the DNR Order in acute care hospitals.

It would also be an Order written by a physician and binding on care staff. It is, however, more comprehensive than the DNR Order as it allows greater consideration of treatment options, often required in situations concerning the care of terminally ill clients in long term care facilities.

'Degree of Intervention' Conference

A meeting to be conducted by the facility for the client to discuss 'Degree of Intervention' to be taken, during final stage of illness or in the event of a sudden collapse. The conference will include, where appropriate, the client (if competent), family members, physician and relevant care staff of the facility.

Each facility will develop policies for each area, based on the Guidelines given in Subsections 2.2 to 2.7.

Cross Reference:

There will be a description of the 'Degree of Intervention' Order, including its purpose, function, and role as a replacement of the DNR Order, for long term care applications.

A definition for 'Degree of Intervention' and the resulting implications for actions in each facility should be included. The various Degrees could be as follows:

Degree One:	Supportive care such as nursing care, relief of pain or fluids, control of fever, etc.
Degree Two:	Therapeutic measures within the limits of the institution such as Degree One plus medication.
Degree Three:	Transfer to acute care hospital if necessary.
Degree Four:	Degree Three plus intensive care and CPR.

The 'DI' Order allows a continuum of care options, appropriate in the management of long term care clients.

There will be a policy which addresses the competency assessment of a client to make treatment decisions regarding terminal illness and sudden collapse.

The physician should be satisfied with the client's competence to make such decisions. Policy statements should clearly reflect the physician's responsibility in this regard.

Cross Reference: Subsection 3.3

2.3.1 **Competent Client**

If the person is competent, the principle of autonomy applies and his/her rights will be respected. This will be stated clearly in such a policy.

Although family members (if available) should be included in discussions regarding treatment options for the client, it should be noted that the competent client has the ultimate decision. Thus, disagreement by another person (including family members) is irrelevant to his/her decision.

Competence means that the client is of sound mind and is well informed of the medical situation and its ramifications. Physician and care staff should also be satisfied that the client is not making treatment decisions under duress. The physician's satisfaction (of the client's competence) should be documented.

Cross Reference: Subsection 3.3

2.3.2 **Incompetent Client**

If the physician is not satisfied with the client's competence to make treatment decisions, it must be clearly documented.

In this case, the physician will have to base his decision of whether to write a 'Degree of Intervention' Order, using any indication of the client's wishes regarding treatment he may have made, while competent. Such indications may be a Living Will declaration or wishes expressed to family members.

Cross Reference: Subsection 3.3

For cases where there were no prior consideration of a 'Degree of Intervention' Order, the facility will have a policy which states what degree (if any) of intervention will be undertaken in witnessed and unwitnessed collapses.

In this policy, the facility may choose to leave the decision regarding intervention at the discretion of the health care professional, or it may establish a predetermined plan of action. Whatever the facility decides, the measures must be clearly stated in such a policy.

It is the facility's responsibility to ensure that staff members understand the policy fully and can comply with it comfortably. Moreover, the physicians concerned must be made aware of such a policy.

There will be a policy regarding the importance and purpose of the 'Degree of Intervention' conference for the client. Policy statements should address such aspects as:

(a) the time after admission to facility, when such a conference will take place,

(b) the parties involved in the conference,

(c) the function and role of the 'DI' Order for long term care applications,

(d) the decisions regarding treatment interventions, and

(e) the review process for discussing changes in decisions, by the client, family, and/or physician. (*see* Subsection 2.7).

Cross Reference: Subsection 2.7

Policy statements must stress the importance of effective communication. Each client will have a designated staff member responsible for the coordination and administration of the 'Degree of Intervention' conference.

There will be clear documentation of all results (consensus reached/ decisions made) and events leading to the writing of a 'DI' Order by the physician. This includes (possibly) a Living Will declaration and discussions with family members regarding treatment options.

As a result of the 'Degree of Intervention' conference, family members will be informed of the decisions (and any subsequent changes) regarding treatment, with respect to the 'DI' Order. In particular,

(a) if a 'DI' Order is to be written, it should be readily accessible by facility staff;

(b) otherwise, it should be documented as having been discussed (including date and participant list) and a future date set to review this decision (of NOT to write a 'DI' Order) with the client and/or family.

There will be a policy to address the review process for all decisions made with respect to the 'DI' Order. Reviews will be conducted for the following circumstances:

(i) to reevaluate an existing 'DI' Order in terms of its appropriateness to the client's wishes, medical condition, and prognosis,

(ii) to reexamine a previous decision of NOT to write a 'Degree of Intervention' Order.

Cross Reference: Subsection 2.5

Procedures for each of the following areas (based on Guidelines of Subsections 3.2 to 3.6) will be established to carry out policies developed under the Guidelines of Section 2.

Cross Reference:

DEATH AND DYING IN LONG TERM CARE FACILITIES

Procedural steps will be established outlining staff responsibility for arranging a client orientation at admission, regarding: 'Degree of Intervention' Order and 'Degree of Intervention' conference.

A facility staff member should be designated for this purpose. In addition, a time frame within which the orientation is to take place must be indicated.

Cross Reference:

Before a 'Degree of Intervention' conference for discussing intervention options is to take place, the physician must be satisfied with the client's competence to participate in making such decisions.

The assessment must be documented. Proper documentation procedure must be given, in conjunction with the facility's policy developed under the Guideline of Subsection 2.3.

Cross Reference: Subsection 2.3

A process for scheduling the initial 'Degree of Intervention' conference will be established.

This includes prompt notification of relevant parties, and acquisition of required documents. For subsequent conferences, the criteria for determining an appropriate review schedule should be stated.

Cross Reference: Subsections 2.5, 2.7

There will be a process for designating a facility staff member responsible for documenting the results of the 'Degree of Intervention' conference. This includes decisions reached and subsequent changes (if any) thereafter.

The communication of these results to relevant persons should be made within an established time frame.

Cross Reference:

In accordance with the facility's policy on treatment intervention for sudden collapse (developed under the Guideline of Subsection 2.4), a plan of action will be given as guidance to staff members.

The specific plan of action will depend on the facility's ability to accommodate particular measures, such as equipment constraints.

In addition, the plan must include:

(i) a process for immediate notification of the event to family and physician, and

(ii) documentation of decisions made and actions taken during the event.

Physicians concerned must be made aware of this plan of action.

Cross Reference: Subsection 2.4

Province of British Columbia
Ministry of Health

© Copyright, 1989

Canadian Cataloguing in Publication Data

Ngan, Patricia, 1958–
Death and dying in long term care facilities
operational guidelines

Written by Patricia Ngan. Cf. Foreword.
ISBN 0-7726-1012-6

1. Terminal care — British Columbia. 2. Terminally ill — Legal status, laws, etc. — British Columbia. 3. Right to die — British Columbia. 4. Long-term care facilities — British Columbia. I. British Columbia. Continuing Care Division. II. Title.

R726.8.N423 1989 362.1'75'09711 C89-092237-3